Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SCOTT & WHITE HOSPITAL MEDICAL CENTER 2401 SOUTH 31ST STREET TEMPLE TX 76508	MFDR Tracking #: M4-10-2194-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUNICIPAL LEAGUE INTERGO Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Claim was denied for missing information – information provided Claim was denied for Authorization – Treatment within treatment guidelines authorization not required Claim not paid according to fee schedule"

Amount in Dispute: $8,496.97

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "This medical dispute concerns reimbursement for treatment the requestor provided between December 18, 2009 and December 23, 2008. The claimant was admitted to the hospital, and multiple surgical procedures occurred. The self-insured has denied reimbursement for said admission and procedures. The provider did not seek preauthorization for the admission or the procedures. The provider also failed to seek concurrent review once the claimant was already admitted to the hospital for a multi-day stay. The self-insured was not contacted by the provider until December 29, 2008, approximately six days after the claimant was discharged from the facility. The provided documentation does not establish that an emergency was occurring such that preauthorization could not have been sought. Further, the provider has attached no documentation establishing why concurrent review was not sought and/or was not necessary, even if the initial admission was on an emergent basis (a point the self-insured is not conceding). Because preauthorization, and subsequently concurrent review, was required, but not sought and received, the requestor is not entitled to any reimbursement for the services underlying the present medical dispute."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
12/18/2008	110 – Room-Board/PVT (5 days) 250 – Pharmacy 258 – IV Solutons	N/A	$8,496.97	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 02/02/2009:

- 197 – Payment adjusted for absence of precertification/authorization.

Explanation of benefits generated from Grant and Weber (contact for Requestor) dated 03/31/2009:

- Per TDI Fee Schedule Guidelines, reimbursement for inpatient hospital services and supplies is made at 143% of the Medicare facility specific reimbursement amount. (851)

Issues

1. Did the requestor seek preauthorization for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to Texas Admin. Code Section §134.600(p)(1) non-emergency health care requiring preauthorization includes inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay. The Respondent indicates the Requestor did not seek preauthorization for the services in dispute nor did they seek concurrent review once the claimant was admitted to the hospital. The Requestor did not submit documentation to support that preauthorization was obtained.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	October 20, 2010 Date
Authorized Signature	Medical Fee Dispute Resolution Manager	October 20, 2010 Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.